(Form No. 2-1) # Beppu City Periodontal Disease Checkup Questionnaire

(To be completed by the examinee)

Name					
Date of Birth		Age at Exam.		Phone Number	

For each of the following questions (Q.1–Q.16), please check (☑) the appropriate box in the "Answer" column. Unless otherwise noted, select only one option.

Question	Answer
1. Questions about the condition of your teeth and mouth	
Q. 1 Are you currently concerned about the condition of your teeth, mouth, or jaw?	☐ No ☐ Yes
① If you answered "Yes" above, check all that apply:	☐ Condition/pain of teeth ☐ Appearance ☐Speech ☐ Bad breath ☐ Condition/pain of gums ☐ Bite/chewing ☐ Dry mouth ☐ Jaw pain ☐ Habits such as teeth grinding/clenching ☐ Other ( )
② If you selected "Condition/pain of gums" above, check all that apply:	☐ Pain ☐ Bleeding when brushing ☐ Swelling/spongy gums ☐ Gum recession ☐ Loose teeth
Q. 2 Do you think you have periodontal disease?	☐ No ☐ Yes
Q. 3 When chewing during meals, which applies to you?	☐ I can chew and eat anything ☐ I sometimes find it difficult to chew due to issues with ☐ I can hardly chew at all
Q. 4 Do your teeth feel sensitive to cold or hot foods/drinks?	☐ No ☐ Sometimes ☐ Always
Q. 5 Compared to six months ago, is it harder for you to eat hard foods?	☐ No ☐ Yes
Q. 6 Do you sometimes choke on tea, soup, or other liquids?	☐ No ☐ Yes
2. Questions about daily habits	
Q. 7 How often do you brush your teeth? (If you have no teeth at all, skip this question.)	Every day (☐ Once ☐ Twice ☐ 3 times or more) ☐ Sometimes ☐ Never
Q. 8 If you selected anything other than "Never" above, when do you usually brush your teeth? (Check all that apply)	☐ After breakfast ☐ After lunch ☐ After dinner ☐ Before bed ☐ Other
Q. 9 Do you use an interdental brush or dental floss?	☐ Every day ☐ Sometimes ☐ No
Q. 10 Do you eat slowly and chew well?	☐ Every day ☐ Sometimes ☐ No
Q. 11 Do you smoke habitually?	☐ No ☐ Yes
3. Questions about dental checkups/treatment	
Q. 12 When was the last time you visited a dental clinic?	☐ Within 6 months ☐ Within 1 year ☐ Not in the past year
① If you answered "Within 6 months" or "Within 1 year," what was the purpose? (Check all that apply)	☐ Treatment ☐ Dental checkup ☐ Prevention (fluoride, cleaning, etc.) ☐ Other
② At that visit, were you told you needed periodontal treatment?	☐ No ☐ Yes
Q. 13 Do you have a regular (family) dentist?	☐ Yes ☐ No
Q. 14 How many of your own teeth do you have? (Exclude wisdom teeth, dentures, bridges, implants; include crowns.)	☐ 20 or more ☐ 19 or fewer ☐ Don't know
4. Other	
Q. 15 Have you ever been diagnosed with any of the following diseases? (Check all that apply)	☐ None ☐ Diabetes ☐ Rheumatoid arthritis ☐ Stroke ☐ Angina, heart attack, or arteriosclerosis ☐ Respiratory disease ☐ Other
Q. 16 For women only: Are you currently pregnant (including possible pregnancy)?	☐ Yes ☐ No